Tennessee Department of Children's Services

Protocol for Safety Systems Analysis Instrument

Supplemental to DCS Policy: 20.29

The pursuit of learning is the characteristic that distinguishes high-quality service delivery systems. Organizations with a well-developed culture of excellence find ways to successfully identify improvement opportunities, implement strategies for change, evaluate change over time, and hardwire what they learn.

The following is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of this instrument is to support a culture of safety, improvement, and resilience. As such, completion of this instrument is accomplished in order to allow for effective communication at all levels of the system. Since its primary purpose is communication, this instrument is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are five key principles of a communimetric measure that apply to understanding this instrument.

Five Key Principles

1. It is designed at the item level. Each item may inform the development of a plan. Each item is individually reliable and valid.

2. The numbers associated with the items translate immediately into action levels.

    a. '0' indicates no evidence, no need for action

    b. '1' indicates latent factor

    c. '2' indicates action needed to mitigate risk and avoid reoccurrence

    d. '3' indicates immediate or intensive action required to prevent recurrence

3. The ratings are made for the opportunity for improvement independent of current interventions. So, if interventions are in place that are masking a need/opportunity, the underlying need/opportunity is described, not its status as a result of the intervention. For example, if a work-around has been created to overcome an equipment failure, the underlying equipment failure should be rated.

4. Culture and development are considered before the action levels are applied. This characteristic is the mechanism to make a common language culturally sensitive and developmentally informed.

5. Items are agnostic as to etiology. The majority of communimetric items are designed to be descriptive and avoid the controversy that can arise from cause-effect assumptions.

This is an effective assessment tool for use in Safety Systems Analysis and in assessing and planning quality improvement projects. To administer the instrument found at the end of this manual, the analyst or other quality improvement personnel should read the anchor descriptions for each item and then record the appropriate rating on the assessment form.

Item Anchors

Cognitive Fixation

Definition: A faulty understanding of a situation due to biases (e.g., confirmation bias, focusing effect, transference).

Influence

0	No evidence of biases that impacted objectivity.
1	Evidence of latency (i.e. no known impact to case, but bias was present)
2	Biases impacted actions/decisions which affected safety and risk assessment or case planning.
3	Biases impacted actions/decisions which affected poor outcomes for clients or staff.

Demand-Resource Mismatch

Definition: A lack of internal resources (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding) to carry out safe work practices.

Influence

0	No evidence of problems with demand-resource mismatch. Assigned case professionals appeared to have needed resources to carry out safe work practices.
1	Evidence of latency (i.e. no known impact to case, but demand-resource mismatch was present)
2	Lack of resources to carry out safe work practices affected safety and risk assessment or case planning.
3	Lack of resources to carry out safe work practices affected poor outcomes for clients or staff.

Documentation

Definition: Absent or ineffective documentation in connection with a particular case.

Influence

0	No evidence of documentation concerns. Documentation was completed within protocol timeframes and clearly communicated relevant details of case activity, case manager impressions, etc.
1	Evidence of latency (i.e. no known impact to case, but documentation concerns were present)
2	Essential documentation (e.g. initial response, case notes, IPAs, FAST, FPPs, etc.) was not completed in TFACTS and/or available in the hard case file and/or contains minimal detail. Lack of documentation resulted in field professionals not having a clear sense of the relevant details of the case and, therefore, affected safety and risk assessment or case planning.
3	Essential documentation is not completed in TFACTS and/or available in the hard case file and/or contains minimal detail. The extent of documentation issues affected poor outcomes for clients or staff.

Equipment/Technology

Definition: An absence or deficiency in the equipment and technology (e.g. communication devices, electronics, safety equipment) used to carry out work practices.

Influence

0	No evidence of problems with equipment or technology.
1	Evidence of latency (i.e. no known impact to case, but issues with equipment/technology were present)
2	The absence or deficiency of equipment or technology affected safety and risk assessment or case planning.
3	The absence or deficiency of equipment or technology affected poor outcomes for clients or staff.

Teamwork/Coordination

Definition: Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people, and teams). *Note: Ineffective teamwork and coordination between an internal supervisor to those internally supervised is captured under the anchor "Supervisory Support."*

Influence

0	No evidence of problems collaborating with other entities involved in the case.
1	Evidence of latency (i.e. no known impact to case, but teamwork/coordination issues were present)
2	Difficulty collaborating with other entities involved in the case affected safety and risk assessment or case planning.
3	Difficulty collaborating with other entities involved in the case affected poor outcomes for clients or staff.

Knowledge Deficit

Definition: An absence of knowledge or difficulty activating knowledge (i.e. putting knowledge into practice).

Influence

0	No evidence of knowledge deficits.
1	Evidence of latency (i.e. no known impact to case, but knowledge deficits were present)
2	Knowledge deficits impacted actions/decisions made and affected safety and risk assessment or case planning.
3	Knowledge deficits impacted actions/decisions which affected poor outcomes for clients or staff.

Records

Definition: Difficulties in obtaining, understanding and utilizing externally-sourced records (e.g., medical records, mental health records, substance abuse records, court records, criminal records).

Influence

0	No evidence of difficulties in obtaining, understanding or utilizing external records.
1	Evidence of latency (i.e. no known impact to case, but concerns were present)
2	Difficulties obtaining, understanding or utilizing medical records affected safety and risk assessment or case planning.
3	Difficulties obtaining, understanding or utilizing medical records affected poor outcomes for clients or staff.

Policies

Definition: The absence, poor clarity, or ineffectiveness of a policy.

Influence

0	No evidence to suggest absent or ineffective policies influenced the case.
1	Evidence of latency (i.e. no known impact to case, but the absence of ineffectiveness of a policy was present)
2	The absence or ineffectiveness of one or more policies affected safety and risk assessment or case planning.
3	The absence or ineffectiveness of one or more policies affected poor outcomes for the client or staff.

Production Pressure

Definition: Demands to increase efficiency. *Note: This anchor is distinctive from Demand Resource Mismatch (DRM), as this anchor describes pressures within casework (e.g., overdue cases, extensive court involvements, child removals in other assigned cases). Though not exclusively, the presence of DRM may impact the presence of Production Pressures.*

Influence

0	No evidence of problems with production pressures.
1	Evidence of latency (i.e. no known impact to case but production pressures were present)
2	Production pressures affected safety and risk assessment or case planning.
3	Production pressures affected poor outcomes for clients or staff.

Service Array

Definition: The availability of a particular service to support safe, healthy environments for clients (e.g. children and families) or staff.

Influence

0	No evidence of problems with service array.
1	Evidence of latency (i.e. no known impact to case, but service array concerns were present)
2	Problems with service array existed and affected safety and risk assessment or case planning.
3	Significant problems with service array existed and affected poor outcomes for clients or staff.

Stress

Definition: Unsafe work practices influenced by stress.

Influence

0	No evidence of stress influencing casework practices.
1	Evidence of latency (i.e. no known impact to case, but stress was present)
2	Stress had an impact on case events which affected safety and risk assessment or case planning—OR—assigned field professional expressed or exhibited moderate difficulty managing the level of stress while assigned the case.
3	Stress affected poor outcomes for clients or staff—OR—assigned field professional(s) expressed or appeared minimally-equipped to manage the level of stress involved in working the case.

Supervisory Support

Definition: Ineffective support, teamwork, availability, or knowledge transfer from an internal supervisor to those internally supervised.

Influence

0	No evidence of problems with supervisory support.
1	Evidence of latency (i.e. no known impact to case, but supervisory support concerns were present)
2	Supervisory support problems affected safety and risk assessment or case planning—OR—a case member disclosed feeling poorly supported by their supervision.
3	Supervisory support problems issues affected poor outcomes for clients or staff—OR—a case member disclosed feeling unsafe as a result feeling poorly supported by their supervision.

In addition to scoring the above anchors, Safety Systems Analysis Review Findings (or other quality improvement related findings) are scored individually, regarding their likelihood to recur within the organization.

Organizational Recurrence

0	No likelihood of recurrence.
1	There is a history of recurrence that appears to have been successfully addressed through organizational improvement(s).
2	There is a likelihood of future recurrence. Though some organizational constructs (e.g. policy, supervision practices, trainings, technology, resource allocation) exist to address the deficit(s), it is unproven or disproven this will successfully reduce recurrence.
3	No organizational constructs currently exist to address the deficit(s).